

**SOUTH DAKOTA BOARD OF COUNSELOR EXAMINERS**  
**APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH**  
**by ENDORSEMENT (ARSD 20:73)**

**NOTE:** Applicant must have a 60 hour Master's Degree (or equivalent) in Counseling, and a minimum of 2,000 hours of supervised post-graduate direct client contact in a clinical setting completed in no less than two years and no more than five, including 100 hours of direct supervision, to be eligible for Licensed Professional Counselor-Mental Health.

I hereby make application for licensure to practice as a Licensed Professional Counselor-Mental Health in the State of South Dakota. **Applications must be accompanied by a non-refundable license application fee of \$100.** A personal check or money order should be made payable to the South Dakota Board of Counselor Examiners. **A photo** (no larger than 3 x 5) **must be submitted** for identification purposes. Please type or print legibly the following information.

**SECTION I. GENERAL INFORMATION**

1. Name \_\_\_\_\_  
Last First MI
2. Name as you wish it to appear on the license \_\_\_\_\_
3. Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_
4. Home Address \_\_\_\_\_  
\_\_\_\_\_
5. Business Address \_\_\_\_\_  
\_\_\_\_\_
6. Home Phone # \_\_\_\_\_ Business Phone # \_\_\_\_\_
7. I have / have not (CIRCLE ONE) made a previous application to South Dakota Board of Counselor Examiners. If yes, please state on a separate sheet of paper.
8. I have / have not (CIRCLE ONE) ever been convicted of, pled guilty to, or pled no contest to, an offense that could have resulted in incarceration for more than a year? If yes, please explain on a separate sheet of paper.
9. I have / have not (CIRCLE ONE) had a license denied, revoked, suspended, or otherwise acted against for any reason in another state, territory, or in South Dakota? If yes, please explain on a separate sheet of paper.
10. I have / have not (CIRCLE ONE) been disciplined by a mental health licensing or certification board or by any mental health related professional organization? If yes, please explain on a separate sheet of paper.
11. I am / am not (CIRCLE ONE) \$1,000 or more behind in child support payments.

**SECTION II. GENERAL REQUIREMENTS**

**STATE BOARD VERIFICATION FORM** must be completed by the state board which issued your active professional mental health counseling license, and be returned to the South Dakota board office.

The NBCC National Clinical Mental Health Counselor Exam (NCMHCE) is requirement for the LPC-MH. If you have not taken this Exam, contact the Board office for the exam information. A fee for the Exam Service will be required.

(continued, over)

### SECTION III. SUPERVISED EXPERIENCE (ARSD 20:73:04)

**ATTACHMENT A – SUPERVISED EXPERIENCE** The applicant must have 2,000 hours of supervised post-graduate direct client contact in a clinical setting experienced in no less than two but no more than five years, and also one hundred hours of direct supervision [at least fifty hours of which shall be face-to-face supervision, the balance may be face-to-face or by secure telephone conferencing or interactive video conferencing]. One hour of supervision, under a licensed mental health professional acceptable to the Board, must take place after each 20 hours of direct counseling contact (1:20 ratio). **Forward Attachment A to your supervisor(s) for completion and verification.**

### SECTION IV. EDUCATIONAL DEGREE

**ATTACHMENT B – COURSEWORK** A 60 hour Master's Degree is required and the specified Areas of Study must be satisfied. Please enclose a copy of your official transcripts.

### SECTION V. AFFIDAVIT

I hereby state that I have fully read and understand the questions presented in this application and have answered them truthfully and completely. I acknowledge that my failure to make a full and accurate disclosure of any information called for herein may result in the denial of my application. I further acknowledge that any license or certification I may obtain on the basis of this application may be revoked or suspended for my failure to disclose full and accurate information herein.

I will furnish additional information or documentation as may be deemed necessary by the South Dakota Board of Counselor Examiners for their verification of the information I have disclosed in this application.

I will not hold myself out as a state Licensed Professional Counselor-Mental Health until the license authorizing me to do so is in my possession.

I hereby declare under penalty of perjury that the foregoing answers and statements are true and correct.

STATE OF \_\_\_\_\_)  
:SS  
COUNTY OF \_\_\_\_\_)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every aspect; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

Dated this \_\_\_\_ day of \_\_\_\_\_, 200 \_\_\_\_.

\_\_\_\_\_  
Signature of Applicant

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 200 \_\_\_\_.

\_\_\_\_\_

NOTARY PUBLIC

My Commission expires:  
(SEAL)

SD Board of Counselor Examiners

PO Box 1822

Sioux Falls, SD 57101-1822

(605/331-2927)

**SOUTH DAKOTA BOARD OF COUNSELOR EXAMINERS  
LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH by ENDORSEMENT**

**STATE BOARD VERIFICATION FORM  
(Applicant, please send this form to your State Licensing Office)**

***ATTENTION:*** By providing us this necessary information we can make a determination whether to grant this Applicant a license. We thank you in advance for your time and consideration.

I, SECRETARY OF THE \_\_\_\_\_ LICENSING BOARD, CERTIFY THAT  
\_\_\_\_\_  
(APPLICANT NAME) WAS GRANTED LICENSE # \_\_\_\_\_ FROM THE  
\_\_\_\_\_  
STATE BOARD ON \_\_\_\_\_, (yr) \_\_\_\_\_.  
AND EXPIRES ON \_\_\_\_\_, 20 \_\_\_\_\_.

I CERTIFY THIS APPLICANT RECEIVED A 60-HR MASTER'S DEGREE IN COUNSELING: yes / no

I CERTIFY THIS APPLICANT WAS LICENSED BY ENDORSEMENT: yes / no

I CERTIFY THIS APPLICANT WAS LICENSED BY GRANDFATHERING: yes / no

I CERTIFY THIS APPLICANT **COMPLETED AT LEAST TWO THOUSAND (2,000) HOURS OF POST-GRADUATE SUPERVISED DIRECT CLIENT CONTACT, AND RECEIVED 100 HOURS OF SUPERVISION BY A LICENSED MENTAL HEALTH PROFESSIONAL.** yes / no IF NO, PLEASE EXPLAIN \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THIS APPLICANT PASSED THE NCMHCE (NBCC clinical exam): yes / no

DATE National Clinical Mental Health Counselor Exam PASSED \_\_\_\_\_

(BOARD SEAL)

\_\_\_\_\_  
SECRETARY OF STATE BOARD

\_\_\_\_\_  
DATE

**Please return this completed form to: SD Board of Counselor Examiners, PO Box 1822, Sioux Falls, SD 57101-1822.**

**ATTACHMENT A -- SUPERVISED EXPERIENCE** (ARSD 20:73:04)  
**LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH by ENDORSEMENT**  
*Separate Attachment for Each Supervisor*

APPLICANT'S NAME: \_\_\_\_\_  
Last First MI

The individual listed above is applying for a license to practice counseling in the State of South Dakota. The South Dakota Board of Counselor Examiners (Licensing Board) requires submission of information by the supervisor(s), which will enable the Board to evaluate the extent and quality of the candidate's supervised experience.

**To be completed by Applicant** (Please type or legibly print):

1. Name of Approved Supervisor: \_\_\_\_\_
2. Nature of setting in which supervised practice took place: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Dates of supervision by this supervisor at this setting: START (mm/dd/yy) \_\_\_\_\_  
END (mm/dd/yy) \_\_\_\_\_
  4. Total number of DIRECT CLIENT CONTACT hours during period listed above: \_\_\_\_\_
  5. **SUPERVISORY HOURS:** Total Number Face-Face \_\_\_\_\_  
Total Number of Group or by Secured Conferencing \_\_\_\_\_

“I attest to the fact these hours are true and accurate.” Supervisor’s Initials \_\_\_\_\_

6. Please describe the nature of the applicant’s duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Please describe the nature of the supervision provided: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT A -- SUPERVISED EXPERIENCE**  
(ARSD 20:73:04)  
**LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH by ENDORSEMENT**

-Continued-KEEP TOGETHER WITH PAGE 4

**To be completed by Supervisor** (Please type or print legibly in ink):

9. I have reviewed the applicant's statements. They are \_\_\_\_\_ / are not \_\_\_\_\_ substantially correct.  
(Please add any corrections on a separate sheet of paper.)
10. The quality of the applicant's performance during the supervision was: (check one)  
\_\_\_\_\_ Outstanding      \_\_\_\_\_ Good      \_\_\_\_\_ Fair      \_\_\_\_\_ Poor
11. My Title at time of supervision: \_\_\_\_\_
12. My type of professional counseling license during the entirety of this supervision\*: \_\_\_\_\_  
License Issue Date\*: \_\_\_\_\_  
{\*Must have been licensed at the highest level of your mental health profession for at least three years  
**prior** to the start of supervision.}
- License Number: \_\_\_\_\_ State of: \_\_\_\_\_

**I attest to the fact the information I have provided above is true and accurate and that I was solely responsible for this applicant's supervision as documented on side one of this Attachment A.**

\_\_\_\_\_  
Supervisor Signature

**ATTACHMENT B**  
**LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH (ARSD 20:73:03)**

To be eligible for licensure through the Board of Counselor Examiners, an applicant must have:

\_\_\_\_\_ A 60-hour Master's degree in Mental Health Counseling approved by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) as listed in "Directory of Accredited Programs," July, 1994;

**OR**

An equivalent Masters degree in Mental Health Counseling or related program which includes coursework in the following areas: **(In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript.)**

\_\_\_\_\_ **Counseling theory:** including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;

\_\_\_\_\_ **Counseling techniques:** including individual counseling practices, methods, facilitative skills, and the application of these skills;

\_\_\_\_\_ **Counseling Internship** (as defined in SDCL 36-32-13 (5))

\_\_\_\_\_ **Human growth and development:** including studies that provide a broad understanding of the nature and needs of individuals at all developmental levels with emphasis placed on psychological, sociological approaches and areas such as normal and abnormal human behavior, personality theory, and learning theory;

\_\_\_\_\_ **Social and Cultural Foundations:** including studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns;

\_\_\_\_\_ **The helping relationship:** individuals working together to resolve a conflict or difference and foster the personal growth and development of one of the two people. At least one of the parties has the intention of function and improved coping with the life of the other party;

\_\_\_\_\_ **Group counseling:** including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;

\_\_\_\_\_ **Life-style and career development:** including areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes and career development exploration techniques;

\_\_\_\_\_ **Individual appraisal:** including the development of a framework for understanding the individual, including methods of data-gathering and interpretation, individuals and group testing, case study approaches, the study of individual differences, and consideration of ethnic, cultural, and sex factors;

\_\_\_\_\_ **Research and evaluation:** including areas such as statistics, research design, the development of research and demonstration proposals, and the development and evaluation of program objectives;

\_\_\_\_\_ **Professional orientation:** professional, legal, and ethical responsibilities including: goals and objectives of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certification and licensing, and the role identity of counselor.

**(MORE, OVER)**

\_\_\_\_\_ **Psychopathology:** including the general principles and practices of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and the general principles and practices for the promotion of optimal mental health:

\_\_\_\_\_ **Clinical assessment:** including the specific models and methods for assessing mental status and the identification of mental illness or abnormal, deviant, or psychopathologic behavior by obtaining appropriate behavioral data using a variety of techniques, including non-projective personality assessments and achievements, aptitude, and intelligence testing, and translating findings in the diagnostic and statistical manual categories;

\_\_\_\_\_ **Clinical theories of counseling:** same as under Counseling Theories:

\_\_\_\_\_ **Psychopharmacology:** including the basic classification, indications, and contraindications of the commonly prescribed psychopharmacological medications for the purpose of identifying the effects and side effects of prescribed psychotropic medications;

\_\_\_\_\_ **Case management:** including the guidelines for conducting an intake interview and mental health history for planning and managing of client caseload manual categories;

\_\_\_\_\_ **Foundation of mental health:** including the specific concepts and ideas related to mental health education, outreach, prevention, and mental health promotion.

**Please return completed form with application to: SD Board of Counselor Examiners, PO Box 1822, Sioux Falls, SD 57101-1822**